Utilization Review Meeting Minutes

February 22, 2018
12:00PM – 2:00PM
Brown Building Auditorium, Concord NH

Meeting:	NH Business Acumen Utilization Review Sub-Committee Meeting	
Facilitator:	Sandy Hunt	
Note taker:	Maureen DiTomaso	
Attendees:	Wendi Aultman	Wendi.Aultman@dhhs.nh.gov
	Debbie Gaudreault-Larochelle	gaudreault@isnnh.com
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	Maureen Rose Julian	maureen.rose-julian@moorecenter.org
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	Frank Truman	frank.truman@moorecenter.org

Discussion

The group reviewed minutes from the January 19, 2018 meeting and there were no changes noted, minutes accepted as written.

Sandy discussed that she hopes this sub-committee can help to develop a uniformed Utilization Review (UR) process. This will help enable Community Based Organizations (CBO) to shift resources to meet demands.

Sandy discussed the worksheet with the group. Sandy will eventually use this worksheet to report to NASUAD. Sandy asked the group if there were any other aspects we should explore regarding Utilization Review.

- Jonathan discussed that UR is broad. We need to define what part of UR this sub-committee is tasked to review. Do we want to be looking at both over-utilization and under-utilization; what adaptive technology could be used to have better outcomes?
- Sandy advised that this sub-committee does not need to come away with all the answers, but to identify areas which we want to drill down into. She understands some members of this sub-committee are confused as to what we exactly we are trying to achieve. The main goal of this sub-committee is to learn, drill down to determine what is important for us to focus on in New Hampshire. From there we can learn from the other states and see how their processes may be able to apply to New Hampshire.
- Ellen noted that when we met previously there seemed to be some clear goals with a timeframe such as the goal of 5% of statewide DD, ABD and IHS waiting list needs will be managed with existing dollars within the system.
    - Sandy noted that this piece is currently being worked on. Bureau of Developmental Services (BDS) has implemented a Wait List (WL) tracker in order to track who is on the WL and if they have a late or delayed start, if so why they are delayed, this will help us to identify one-time funding and then BDS will work with Area Agencies (AA) to reallocate the funds identified. This is already in process and Sandy will be able to report to NASUAD with this information.
- Concerns were raised regarding individuals who are funded one-to-one, but what happens when the vendor agency is short staffed, then that individual goes to a one-to-two or a one-to-three and yet the billing remains the same. Or vendors may have an individual who is funded for one-to-three, but is in crisis and needs to go to a one-to-one. How can we allow AA to manage individual's needs in real time and what would that then look like for vendor agencies? Also you have some individuals who still have 20-year old budgets.
    - Sandy noted that we want to get to a place where AA can report the actual cost of serving individuals.
- Area Agency's work differently than Choice for Independence (CFI) Case Managers. Within CFI a Case Manager can increase the budget for CFI and have that flexibility.
- Maybe we can look at what technical assistance is available.

- Sandy noted that Missouri is breaking down the silos within state agencies. They are working together to leverage the information. Although Missouri does have the same struggles as New Hampshire does. The idea of this sub-committee is to look at where we are at in our state, bring that information to NASUAD and then they will steer us on specific directions to drill down into.

- There are some states which are more engaged with Managed Care Organizations (MCO) and some of these issues are already in place and they are now working on other aspects.
- Do other states have such differences within their waiver systems (where CFI is so different from the ABD, DD waivers)?
    - Some states have Area Agencies on Aging (AAA) organizations. These are agencies which cover all programs for aging & disabilities. In New Hampshire CFI eligibility is medically based and not managed by the Area Agencies (Organized Health Care Delivery System). The waiver assurances for ABD, DD and IHS are very different from CFI. New Hampshire is also unique that we have ten (10) Area Agencies which deliver services locally (or through contract). They are basically the Medicaid provider agencies. In other states, the providers bill the state directly. This is a learning process and we are trying to find similarities, but it's proving difficult because New Hampshire is so unique, so discussions with other states are challenging.
- Ellen asked if we have met Priority #2 with the WL tracker.
    - Sandy noted that it does meet the objective.
    - Ellen noted that it seemed the goals for today have shifted.
    - Sandy asked the sub-committee to come up with three (3) or less strategies. Then under those determined strategies we'll come up with specific steps.
- Jonathan asked how we can determine if level of care is meeting the assessment at the time and if the individual is getting the right services and/or supports at that time.
- Sandy stated that we should look back at the three (3) bullets:
    - By 2/1/2018 a Utilization Review format will be established.
    - By 4/30/2018 all agencies and CBOs will be trained in Utilization Review.
    - By 7/1/2018 all agencies will have a Utilization Review process established and followed.
    - By 6/30/2018, 5% of statewide DD, ABD and IHS waiting list needs will be managed with existing dollars within the system).
        - Sandy stated she thinks we are fine on this bullet. The wait list registry was not in place, or in effect, when this proposal was written. BDS is still making changes to it.
        - The Wait List Registry is used when an individual is in need of services; they are added to the registry. BDS can then look at the individual's needs and determine what funding is needed. Once the funding is received, that individual is taken off the WL registry and then added to the Wait List Tracker. If services do not start BDS can now track those funds and reallocate as one-time funds to other

individuals throughout the state. BDS has just recently added an ABD and IHS to the tracker.

- Individuals need to be on the WL Registry in order to be on BDS's radar and BDS depends on information received from the Area Agencies.

- Ellen asked then are we looking at the format for UR? What UR format can be applied to BDS, BEAS conceptually and involve provider agencies as well?
    - Sandy said some action steps will apply to CFI and some don't. It's OK. Everyone can contribute to the process and then we'll feed the information into the four (4) bullets which can then be reported to NASUAD.
- Sophia discussed the scope of Region 9's UR process. Sophia is from Region 9 (Community Partners) they have regular meetings regarding Prior Authorizations (PA), Vendor Meetings, Internal Community Supports Services (CSS) and UR meetings, SAP, Case Management, WL etc. Region 9 does not bill in NH LEADS. Instead, they use Crystal Reports. They look at budgeted weekly hours and can then see any variances and then follow-up to see why there are discrepancies. They look to find patterns; this in turn helps us with funding. The information is based off of real information. Identified SEP or CSS patterns of non-use we can then put into ZUNK which we can use for crisis.
    - Debbie asked this is determined at an Area Agencies level, but how does that trickle down to providers? We need flexibility in CBOs to have the ability to see under-utilization. We should maybe look at more flexibility at the vendor agencies.
    - This is a gray area. According to the Corrective Action Plan, in the future providers should have the ability to bill Medicaid directly. At that point, would vendor agencies have more control over the budgets? Could it be set up like CFI providers and they can only bill for what has been authorized? In the CFI system we can see what's been used by the providers. There is the ability to see under-utilized funds. We can see what's been budgeted, know where there are extra funds, how to look for them, who in the state manages them in the Medicaid system.
- Sandy stated that under the new CMS rule, providers can go either through the AA or through direct billing. The directive from CMS is to have this as an option. BDS is looking at developing a new IT system which may include CFI and other Divisions under DHHS as well. We don't know what the future looks like, but this sub-committee needs to stay focused. Sophia noted that they came up with their process in response past to audit findings. Maybe this sub-committee can suggest that we look at what they created, communicate with vendors and determine if this is something that we could implement statewide?
- Sandy noted that maybe we could identify people in transition and it could become an action step for this sub-committee.
    - It was noted that providers would like to be more involved regarding the budgets at the AA level.
    - Some, but not all vendors report on who are over/under-utilizing services.

- Wendi noted that with the UR process and even with the flexibility of CFI, there is not a consistent monitoring system. There is not a formal protocol process statewide. We need to determine what is working well and what is not working well. Look at the financial perspective and bottom line, but that doesn't move into the UR process. Whatever is not provided does not go back into the bucket. We don't really know what providers are struggling with. We do not have a systems perspective.

- Would the AA be interested in exploring inviting vendors to the table to help determine priorities, although it was noted that you cannot move funds across service lines. We should get a read of where we are in the process.
    - Is this one-time reallocation? In order to make changes, there needs to be changes in two (2) PA's, there is a lot of administrative work. PA's have to start and end at the same time. It's not flexible.
    - Sandy noted that she will need to speak to the PA Unit and Jennifer Doig to see if this is a possibility. If there is data that AAs can share with Vendor Agencies, it informs the process and we can visualize action that can come from that data. If a vendor gets a report about underutilization, that vendor can create an argument to shift resources from individual A to individual B and then the vendor could discuss further with the AA.
- Jonathan advised that we need to think of the legal structural component. There are some vendor agencies who are for profit and some which are nonprofit. Some vendor agencies are small and do not have the ability for this type of tracking.
    - We would need to de-identify information as needed.
    - Inherited budgets / historical budgets are very low. There is a great struggle for vendors and it is a major issue. Some AA have good communication with vendors, others do not. So if a vendor is asking for an increase, there is sometimes no ability to negotiate. Sandy noted that AA can negotiate for their individuals.
    - On specifically historical budgets, if a vendor agency is faced with discharging, the budget is so low that other vendors say no.
- Could historical budgets be reviewed to be increased?
    - You can ask for enhancements through the wait list if the person's service needs change.
    - Case Management side has these same issues.
- Sandy asked the group to think about how we can work these concerns into action steps?
    - Maureen Rose Julian proposed that once a year we could have a request for a permanent reallocation. If this was done yearly, the realignment might reduce the WL and utilize funds better, we could even fulfill some enhanced budget requests.
    - This might help AA move around and maintain funding. If vendor has under-utilized funds, and AA cannot realign those funds, the AA will need to focus on the individuals being served more than they have to focus on the vendor agencies.
        - Sandy did note that ultimately the vendor cannot collect any more money than what is being billed for. It will take exercise at the AA level to help assure vendors use the full budgeted amounts.

- NH LEADS is where we could determine over-utilizations. It would be in the unbilled status.
- Vendors cannot see over-utilization. Vendors may be providing more than what is in the budget. That is not captured in the current system.
  - Vendors should be speaking with the AA directly on these issues.
- Concerns over DSP rates and how vendors can bill for a certain rate allowed by AA, but the vendors themselves may choose to increase the hourly wage because with the wage so low it is hard to hire reliable staff.
- Previously there was the ability to reallocate, but it is tied to PA dates.
- There will be issues with the lowest historical budgets.
  - There have been significant increases in costs, but not within the budgets.

- It was suggested that part of the PCP process include a budget review, which will happen once a year and look at the goals within the SA. Could this group look at creating a cost-of-care dashboard? It could be created with AA and vendor agency input. It might be able to show where funding currently is, and what it will need to be based upon what has been used.
  - We need to identify the gaps of what individuals service needs are and what vendors need to provide services.
  - We need to focus on the services delivered, not the rate of pay between vendors. Some vendors work differently in terms of what they pay DSP or benefit packages. We would not want to include that in the cost-of-care dashboard, it would be more of a snapshot of services.
  - This would not capture everything that the vendors do to help support individuals. If you have a cost-of-care metric, you could then look at all the services an individual is receiving. This kind of data would be useful to finding true costs.
- Wendi suggesting creating a process to predict and plan. This will allow a strategy for budget development.
  - It would be an exercise for AA to work with vendors to determine what the most difficult historical budgets are. Start with those and take a closer look to see how far off they are in the system. Balance out what it is currently and what it should look like.
- Sandy asked the group for volunteers to come up with a draft of what a cost-of-care dashboard could look like.
  - Wendi noted that this is already done under CFI and she will share the process they are currently using.
  - HRST could be a component to this dashboard, but there will need to be a way to connect it to have an interface with the billing/PA system.
  - Kristina noted that we need to keep in mind that we need to also look at this from the vendor agency point of view as well. Assuming the cost of care rate has already been set, but vendors will have a different cost of care.
    - Just a note our terminology should be cost of services instead of cost of care.

- Would we need different dashboards, one for AA and one for vendors?
    - The dashboard would be per individual, information on specific services.
    - CFI case managers do not use the HRST program. Also for CFI individuals when their budgets have not been developed, they can push up to Commissioner Level for approval as long as the total cost will still be less than a nursing home stay.
    - Many Service Authorizations go unfilled. There are units floating on the budget side. The challenge is the Service Authorization change cannot be approved until there is a provider. There could be a change from 4 hours to 25 hours, but until a provider is added, we don't want to lose sight of these. We need to capture the needs in order to make progress and improvements.
    - Reports could be generated on opened service authorizations.
- What is the action item which would be the outcome if this group creates this? What if we do this and the information just sits for a year until all the information is inputting into the pot?
    - We could look at this as the overall view of the system; we could roll-out as an annual exercise after.
- Could the Support Intensity Scale (SIS) tool be applied as well?
    - SIS does not capture higher behavioral needs, it is a good tool to use, but it does not encompass everything.
- Volunteers:
    - Le'Ann Milinder
    - Debbie Gaudreault-Larochelle

- We need to determine what we want to collect for information. We need to determine what we already collect for data already. Sandy would like to set up a conference call with key players to come up with bullets of what we will want to have on the cost-of services dashboard.
    - We want to create questions to help us understand. We need to look at the questions and apply them internally to see what individual needs are for services. We can create good questions which will work towards creating a plan that works.

Outcomes of this meeting and changes made to the Strategies and Action Steps worksheet:

- Priority #2 Action Step #1 – the group identified the need for training and needs to determine what training will be offered to which audience as a potential barrier / solution.
- Priority #2 Action Step #2 – added "resources"
- Priority #2 Action Step #4 -Jonathan Routhier and Sandy Hunt will be responsible.
- Strategy B – Action Step #1 – reworded too "Cost of Services Dashboard (IT) – Identify true cost of the services that we provide. Cost = Cost to whom? Develop a dashboard geared towards the individual; indicate if it's an AA or a Vendor agency."
    - Person(s) responsible: LeAnn Milinder; Debbie Gaudreault; Rae Tanguay; Maureen Rose-Julian; Kim Shottes; Lorrie Winslow; Jonathan Routhier

    - Resources available - CFI currently uses data that feeds into an algorithm. DD/ABD adult uses SIS and HRST which are potential sources of information.
    - Potential Barriers / Solutions - Challenges around lack of data in HRST and SIS
- Strategy B – Action Step #2 – added "within waivers – propose an annual realignment for budgets that need less/more units on the PA – budget neutral per AA without the current barriers (service line / PA renewal date/service level)."
    - Person(s) responsible - Both CFI and DD/ABD should review the cost of services within each system.
    - Collaborators - BDS PA unit and Finance
- Strategy B – **Added** Action Step #3 - Vendor agencies receive a report from the Area Agency which outlines Units that are underused / overused.
- Strategy B – Added Action Step #4 – rewording the action step too "CFI: Case manager is very involved, case manager handles budget. (Request is subject to review)."
    - Resources Available / Required - Underutilized units are viewed by BEAS and Provider Agencies
- Strategy C – Changed wording from Level of Care to Level of **Service**
- Strategy C – Action Step #1 – Resources available/required - Person Centered Planning Process? Annual Review
- Strategy C – Action Step #2 – Added wording "Pinch points for CFI, not being utilized as well as it could be."

Next meeting: March 26, 2018

1PM – 3PM

Main Building, 2nd Floor, Kimball Conference Room

Attachments:

Updated Strategies and Action Steps worksheet